THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DEPARTMENT OF TELECOMMUNICATIONS & ENERGY

Transportation Division
One South Station – Boston, MA 02110
(617) 305-3559

Medical Evaluation Form
For School Bus Operator Certificates

I hereby authorize the physician completing this form to discuss and release any or all medical records pertaining to its content with or to representatives of the Department of Telecommunications and Energy.

_____ _____
Applicant's Signature Date

Patient Information: Name_____ DOB_____

Lic. #_____ End._____

This form must be <u>FULLY COMPLETED</u> by a physician (a <u>MEDICAL DOCTOR</u> who is licensed to practice in the Commonwealth of Massachusetts).

1. **Distant Visual Acuity (Snellen):** Left eye: (OS) 20/____ Right eye: (OD) 20/____
   Does the applicant use corrective lenses for driving? Yes___ No___
   (If the applicant uses corrective lenses for driving, please specify visual acuity above as corrected with Rx).
   Combined horizontal peripheral field of vision (record in degrees): _____
   Is the applicant able to distinguish the colors red, green, and amber? Yes___ No___

2. **Hearing:** Left ear:_____ Right ear:_____
   Does the applicant use a hearing aid? Yes___ No___

3. Does the applicant have a **respiratory disease/disorder**? Yes___ No___
   Does the applicant use supplemental oxygen? Yes___ No___
   Please indicate the applicant's oxygen saturation rate (with supplemental oxygen if used):_____
   Additional comments: _____
   _____

4. Is the applicant currently diagnosed as having **diabetes mellitus**? Yes___ No___
   If so, (1) has the applicant ever had a hypoglycemic episode or spell? Yes___ No___
   And, (2) is the applicant **insulin dependant**? Yes___ No___
   Additional comments: _____
   _____

5. Is the applicant currently diagnosed as having **Epilepsy**? Yes___ No___
Has the applicant ever had a **seizure** or other type of **altered/loss of consciousness**?
Yes___ No___
If so, please explain and state type and date of last episode: _____
_____
Additional comments:_____

6. Does the applicant have a **cardiovascular condition**? Yes___ No___
If so, (1) does the applicant have an implanted cardiac defibrillator? Yes___ No___
(2) does the applicant have AHA functional Class III or IV heart disease?
Yes___ No___
(3) specify AHA functional class and symptoms: _____
_____
Additional Comments: _____
_____

7. Does the applicant have a **loss of foot, leg, hand, or arm** likely to interfere with safe driving?
Yes___ No___
Does the applicant have an **impairment of use of foot, leg, fingers, hand, or arm** likely to interfere with safe driving? Yes___ No___
Does the applicant have any **other physical condition or limitation** likely to interfere with safe driving? Yes___ No___
If so, please describe the patient's medical condition: _____
_____
Also, please describe the extent, frequency, and control of the symptoms of the patient's condition or disability which may affect his/her ability to operate a school bus:_____
_____

8. Is the patient on any **medication(s)**? Yes___ No___
If so, please list medication(s) with dosage(s):_____
_____
Are these medications, separately or combined, likely to interfere with the ability to operate a school bus safely ? Yes___ No___

9. Has the applicant for or obtained a RMV issued Disability Placard/Plate? Yes___ No___

10. Please check one of the following categories:
I hereby certify that in my professional opinion and to a reasonable degree of medical certainty
___ that the patient named above **IS** medically qualified to operate a school bus safely.
___ that the patient named above **IS NOT** medically qualified to operate a school bus safely.

Additional comments: _____
_____
_____
_____

Physician's Name: _____ Registration #: _____

Street Address: _____ City: _____

Signature: _____ Date: _____
